South West
Strategic Clinical Network

Zero Suicide Collaborative

Charter

August 2014

1. What are we trying to accomplish?

General description

1.1. The vision of the South West Strategic Clinical Network for Mental Health is to bring together people with lived experience, cross-system care providers and other stakeholders to reduce suicides to zero across the south west of England by October 2018.

1.2. For the purposes of this collaborative, suicide will be defined as 'an act that intentionally ends one's life'.

1.3. It is acknowledged that to achieve the vision of getting to zero suicides will not be easy, but it is an aspiration that is worthwhile, compelling and inspiring. If we can save one life through this work, the effort will be worthwhile.

1.4. Multiple organisations will work together and through joint effort will achieve this common aim. A number of projects will be prioritised, with agreed aims, according to the degree of belief that they will get us to where we want to be.

1.5. Collaborative efforts will include Local Authority's, as the lead agency for the prevention of suicide. These are as follows:

Cornwall	Wiltshire
Devon	Swindon
Torbay	Bath & North East Somerset
Plymouth	North Somerset
Somerset	
Bristol	
Gloucestershire	

1.6. Collaborative efforts will be focused around communities of action based around prioritised interventions. As these communities of action develop they will be expected to draw in people with lived experience as part of the team.

1.7. Key areas of work will reflect those set out in 'Preventing Suicide in England: a cross-government outcomes strategy to save lives':

- reduce the risk of suicide in high risk groups;
- tailor approaches to improve mental health specific groups;
- reduce access to means of suicide;

- provide better information and support to those bereaved or affected by suicide;
- support the media in delivering sensitive approaches to suicide and suicidal behaviour;
- support research, data collection and monitoring.

Reason for the improvement effort

1.8.   "In England, one person dies every 2 hours as a result of suicide. When someone takes their own life, the effect on their families and friends is devastating." (Norman Lamb, Preventing Suicide in England 2011)

1.9.   Suicide is a leading cause of premature death in England. Suicide rates in the south west of England are rising and this region has high levels of suicide as compared with other regions in England.

1.10. In terms of impact on people, the following has been calculated:

- 600 suicides in the South West a year (Public Health England Website)

- Each of these 600 suicides impact on approximately 20 family members, 20 friends, and 20 colleagues, so 60 people

- Multiply 600 by 60 with the result that 36,000 people are very significantly affected (research in Lancet Psychiatry), so the human cost is massive

- It is estimated that the financial cost of each suicide is £1.5 million

1.11. Suicides must be seen as avoidable. There are many ways in which public services, communities, individuals and society as a whole can work together to support people differently so that taking their own lives is not the only option.

1.12. Improving the Mental Health of the population will undoubtedly support a reduction in suicide rates as outlined in 'No Health without Mental Health' and 'Healthy Lives, Health People'.

1.13. There has been considerable work carried out to understand what contributes to people choosing to take their own lives. Much of this is outlined in the Department of Health document 'Preventing Suicide in England (2011)'. The problem is not what needs to be done but how can this be done.

1.14. The NHS priorities include:

- preventing people from dying prematurely (domain 1);
- enhancing the quality of life for people with long term conditions (domain 2);

- ensuring people have a positive experience of care (domain 4);
- treating and caring for people in a safe environment and protecting them from avoidable harm (domain 5);
- promoting equality and reducing inequality in health, including parity of esteem for people with mental health problems.

1.15. The Mental Health Crisis Concordat focuses on improving services for people experiencing mental health difficulties. This commits a variety of providers across public services to work together to improve the system of care and support so that people in crisis, because of a mental health condition, are kept safe and helped to find the support they need whatever the circumstances in which they first need help and from whichever services they turn to first.

1.16. This improvement collaborative meets these regional and national priorities and is designed to promote multiagency working to make the South West a safer place to live with mental distress.

1.17. In order to make the gains needed to reduce these avoidable deaths, we need to make systems changes to the ways we support people when they are distressed and no longer feel that life has any meaning for them.

1.18. The South West of England has been at the forefront of patient safety and quality improvement in England. The acute healthcare sector, community care and mental health care all have experience in working within a safety collaborative and have demonstrated that when they work together using the evidence bases available to them and quality improvement methodology, they can provide care that is safer and offers better outcomes for people using services.

1.19. All the collaboratives have worked with the Institute for Health Improvement (IHI) in Boston, USA and have used the Breakthrough Series Collaborative Model as the learning system, and the Model for Improvement as the framework to support rapid, reliable and sustainable changes in the systems of interest.

1.20. This project proposes that these can be applied across a wider system to support the implementation of strategies that have been identified to reduce the risk of suicide.

1.21. The wider system will include Public Health, Clinical Commissioning Groups and people with lived experience and the wider community recognised as having increased risk of suicide.

Expected outcomes

1.22. The specific objectives of the Zero Suicide Collaborative in the first year are:

- to establish a South West learning and improvement collaborative made up of whole system multiagency communities of action and which include people with lived experience;

- communities of action will each agree on an improvement project which is achievable in the first year. Key areas will be prioritised from the driver diagram based on the degree of belief that improvement in these will contribute to achieving the vision of getting to zero suicide.

- improvement projects will involve improving a system or process, or part of a system or process, and include an aim, how improvement will be measured over time, and the changes that will be tested.

- each organisation within the community of action will develop a plan for implementation and spread of the changes that have shown to demonstrate improvement in outcomes;

- learning and sharing between agencies and between communities of action will become the norm;

- through testing changes and observing or measuring the results, begin to build knowledge about how to implement what we know contributes to the prevention of people choosing to take their own lives.

2. How do we know that a change is an improvement?

Measurement

2.1. Successful measurement is the way we will know if the changes that are being made are leading to improvement. Measurement does not have to be difficult or time-consuming. The key is to pick the right measurements, so results can be seen quickly and interventions adapted accordingly.

2.2. As the work progresses, a measurement strategy will be developed which will be made up of outcome, process and balancing measures. As each project is identified a 'family' of measures will be developed and tested to enable us to see if the changes are resulting in the improvement predicted. The point is to reliably implement the processes we believe will be most effective and measure the reliability against a group of sub-objectives.

2.3. In addition to the measurement strategy related to the projects, the following data will be available:

- Number of delegates and organisations attending the launch event

- Number of one and two day learning sessions over the year

- Number of attendees at each learning session broken down into new people and those returning

- Number and names of the organisations participating in the learning sessions

- Results of a pre and post project questionnaire to participants aimed at gaging their level of knowledge and skills in improvement science.

3. What changes can we make that will lead to improvement?

Specific changes to be tested

3.1. Driver diagrams will be developed In order to conceptualize an issue of suicide prevention. These will determine the system components, and contain change concepts that can be used to create projects which will then create a pathway to achieve the vision.

3.2. Person and Carer involvement

3.3. The Zero Suicide Collaborative will place people with lived experience at the heart of the programme. This will provide an opportunity to design systems through their eyes and accelerate learning and change.

3.4. Each group in the governance structure has representation and organisations will be asked to consider how they will involve people with lived experience in this work.

3.5. Communities of action will be expected to involve people with lived experience and carers.

3.6. Money has been attributed from the budget allocation to support people with lived experience who engage in this project

3.7. The Zero Suicide Collaborative includes the following stakeholders:

- People with lived experience
- Clinical Commissioning Groups
- Area Teams
- General practice
- Providers of secondary Mental Health Services
- Third sector organisations
- Samaritons
- Police service
- Ambulance service
- Academic Health Science Networks
- Local Authorities
- Coroner's office
- Children's services
- Public Health

3.8. **Project constraints:**

- the funding received by the Strategic Clinical Network is for one year only. In order to achieve the vision, this collaborative will need to continue and member organisations will be asked to consider how this work can be sustained into the future.

3.9. **Exclusions:**

- the collaborative is focused on learning and improvement and the measurement of the impact of changes made. It is not intended to be a research programme.

4. Resources

4.1. The contacts listed below will be the main contacts for this programme:

- Dr Adrian James
  Consultant psychiatrist and chair of the collaborative
  Devon Partnership NHS Trust
  Adrianjames@nhs.net

- Dr Ellen Wilkinson
  Medical Director, Cornwall Partnership NHS Foundation Trust
  Clinical Lead for the Zero Suicide Collaborative
  ellen.wilkinson@cft.cornwall.nhs.uk
  01208 834609

- Dr Helen Smith
  Medical Director, Devon Partnership NHS Trust
  Clinical Lead for the South of England Improving Safety in Mental Health
  Collaborative
  hsmith7@nhs.net
  01392 208866 (switchboard)

  PA: Nicola Jones
  01392 674116
  nicola.jones10@nhs.net

- Corinne Thomas
  Programme Director
  Corinnethomas67@gmail.com

- Sue Wood
  Programme Manager
  sue@nascent.works

- Alan Harding

Programme Administrator
alan@nascent.works

4.2.   The Institute for Healthcare Improvement seeks to improve health care by supporting change. One of the ways they do this is via collaborative learning. Specifically, they use a model for achieving breakthrough improvement which they have been continuously improving since its developemnt in 1995, called the Breakthrough Series.

4.3.   The Breakthrough Series is a learning system designed to help teams close the gap between what we know and what we do. It creates a structure in which teams can easily learn from each other and from recognised experts in the topic area where they want to make improvements. it works best when there is a deficit in quality which can be identified by teams as 'unacceptable' and where there are pockets of excellence which can be used for learning.

4.4.   Learning sessions are held where multidisciplinary teams working on a specific improvement topic are brought together. They learn about the Model for Improvement that enables front line teams to test evidence based change ideas locally, and then reflect, learn, and refine these tests. As teams mature they learn even more from each other as they report on successes, barriers, and lessons learned both in general sessions and in their storyboard presentations.

4.5.   Between learning sessions there are action periods where teams test and implement changes and collect data to measure the impact of those changes. Teams are asked to submit monthly progress reports and key faculty review these reports to provide feedback and coaching to the teams, and also to assess overall progress of the Collaborative.

4.6.   Communities of action will commit to working together and will attend **three Learning Sessions**. The Learning Sessions will provide the opportunity to:

- gather new information on strategies to improve the safety of the care delivered and on process improvement from faculty and colleagues;
- share information and learn from each other;
- develop detailed improvement plans for each organisation/community of action.

4.7.   There are five principles central to improvement:

- knowing why you need to improve;
- having a way of getting feedback to know if improvement is happening;
- developing a change that you think will result in improvement;
- testing a change before there is any attempt to implement;
- implementing the change.

4.8.   Collaborative participants learn an approach for organising and carrying out their local improvement work, called the Model for Improvement. This model was developed by Associates in Process Improvement (*The Improvement Guide,* Jossey-Bass, 1996) and incorporates the key elements of successful process improvement identified above. These are: specific and measureable aims, measures of improvement that are tracked over time, key changes that will result in the desired improvement, and a series of cyclical testing cycles known as 'Plan, Do, Study, Act' (PDSA), during which teams learn how to apply key changes to their own organisation (see Appendix 2).
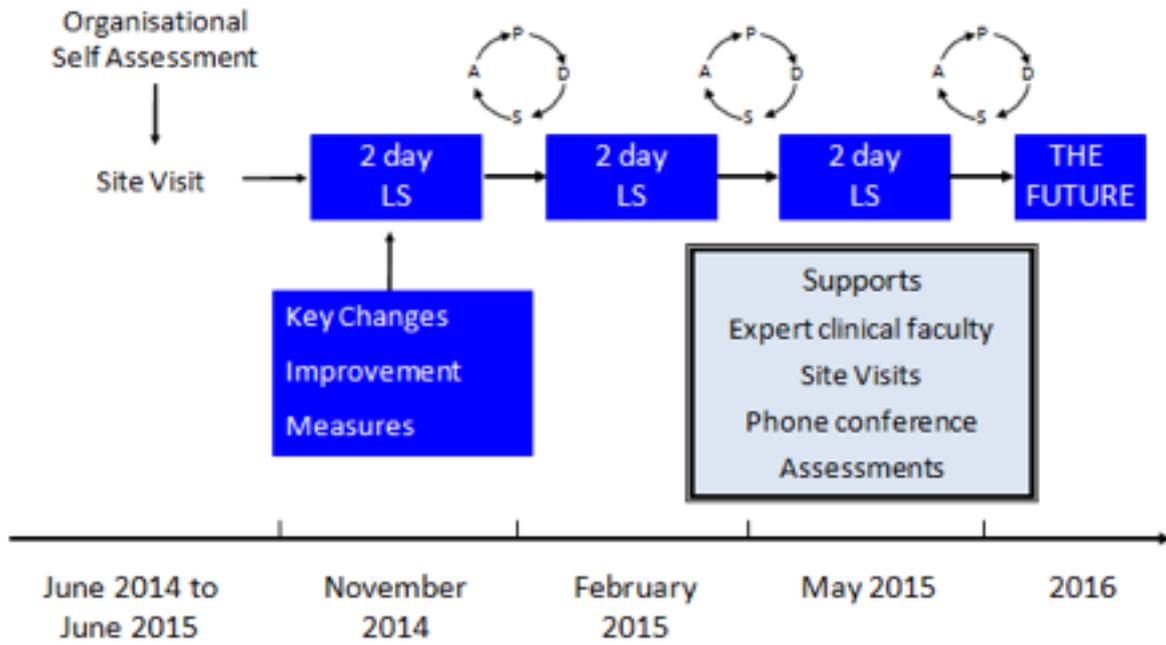
Governance arrangements

4.9.   The governance arrangements for the management of this project involves a Reference Group and a Steering Group. Further details are outlined in Appendix 3.
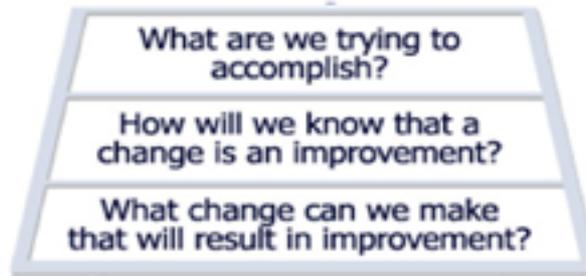
Communications plan

4.10.   See appendix 4

IHI Breakthrough Series Collaborative Model

Model for Improvement

When you combine the 3 questions with the…

PDSA cycle, you get…

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan

Study | Do

…the Model for Improvement

**South West Strategic Clinical Network for Mental Health
Zero Suicide Collaborative**

Governance arrangements

1. Introduction

1. The vision of the South West Strategic Clinical Network for Mental Health is to bring together people with lived experience, cross-system care providers and other stakeholders to reduce suicides to zero across the south west of England by October 2018.

2. It is acknowledged that to achieve the vision of getting to zero suicides will not be easy, but it is an aspiration that is worthwhile, compelling and inspiring.

3. Multiple organisations will work together and through joint effort will achieve this common aim. A number of projects will be prioritized, with agreed aims, according to the degree of belief that they will get us to where we want to be.

4. Suicide in this collaborative will be defined as 'a deliberate act that intentionally ends one's life'. Exclusions will be noted in the collaborative charter.

5. The purpose of this paper is to set out the Governance arrangements for the Zero Suicide Collaborative.

2. Remit of the Reference Group

2.1. On behalf of organisations within the collaborative, the Zero Suicide Reference Group will:

- endorse the collaborative agreement, driver diagrams and change packages, and the measurement strategy;

- agree expectations of participating organisations;

- review progress against the delivery of the aim;

- propose ambitions and measures for future work related to improving safety in mental health;

- make the links with other organisations concerned with reducing suicide in the South West.

3. Membership of the Reference Group

3.1. Membership of the Reference Group will consist of:

- Chair of the South West Strategic Clinical Network for Mental Health (Chair for this collaborative;

- Clinical lead of the South of England Improving Safety in Mental Health Collaborative (clinical lead for this collaborative);
- Programme Director
- Programme Manager;
- Improvement Advisor;
- Programme Administrator;
- People with lived experience;
- Representatives from the following organisations:
  - West of England Academic Health Science Network
  - South West Peninsula Academic Health Science Network
  - Local Authority
  - Samaritans
  - Police Service
  - Ambulance Service
  - Fire Service
  - Coroner's office
  - Clinical Commissioning Groups
  - Public Health
  - Providers of secondary Mental Health Services
  - Area Teams
  - General Practice
  - Health Watch Somerset

4.   Remit of the Steering Group

4.1.   The steering group will be responsible for:

- developing the collaborative charter;
- organising development of collaborative resources including driver diagrams and measurement strategy;
- faculty recruitment;
- enrolment of participating organisations and teams;
- preparation of learning sessions;
- arranging support during action periods;
- ensuring there is full and proper engagement of participants within the collaborative;

- ensuring the operational business of the collaborative is managed.

5. Membership of the Steering Group

Dr Adrian James, Collaborative chair

Dr Ellen Wilkinson, Collaborative medical lead

Dr Helen Smith, South of England Improving Safety in Mental Health Collaborative Clinical lead

Dr Tricia Woodhead, Improvement Advisor

Corinne Thomas, Programme Director

Sue Wood, Programme manager

Alan Harding, Programme Administrator

Amelia Brooks, South West Peninsula Academic Health Science Network

Hazel Crook, Cornwall Area Team, NHS England

Tobit Emmens, Devon Partnership NHS Trust

Robert Gough, person with lived experience

Debbie Stark, Director of Public Health for the Peninsula

6. Working Arrangements and support

6.1.   The Reference Group will meet two monthly and receive:

- progress reports from each participating community of action;
- verbal updates from the steering group.

6.2.   Agendas and papers will be available to members at least one week in advance of the meeting and the notes of previous meetings are circulated no more than two weeks after each meeting.

6.3.   The Steering Group will meet monthly until Learning Session 1.

6.4.   The Chair of the collaborative will be accountable for the Zero Suicide Collaborative Project and report on progress to the Strategic Clinical Network oversight group. The chair will keep the Mental Health Improvement Group informed about this work.

6.5.   The Programme Director will report to the chair of the collaborative. The Programme manager will report to the Programme Director.

Communications Plan Outline:

A structured approach to communications is essential to ensure engagement of stakeholders, increase awareness of this important subject and maximise the impact of interventions.

There are three main stakeholder groups with which to communicate:

- **The general public** – many of those at risk of suicide are not currently known to health and care services and consequently it would be inappropriate to focus purely on 'patients'. This project aims to increase the understanding of the general population of the South West regarding suicide risk and strategies to prevent suicide.

- **Care givers** – frontline health and social care staff are ideally placed to identify those at risk of suicide given the frequency and variety of care interactions that occur. Our intention is to increase the knowledge of these staff to enable them to identify and support appropriately those at risk of suicide.

- **The media** – popular media is an important influence in attitudes and approaches to suicide. We intend to use the local media as a vehicle to improve and catalyse a more open and supportive approach to suicide in general.

Given the scale and diversity of our stakeholder groups, we will need to emply a number of communications techniques and make use of a variety of media:

- **Website** – a webpage will be created as a central portal through which any interested party can access advice and support on how to get involved with the project or learn more.

- **Launch event** – a regional event is scheduled to take place in the Great Hall at the University of Exeter on 8th October 2014. All potential opportunities to maximise the publicity and impact of this event will be explored in advance.

- **Networking events** – this project uses the Institute for Healthcare Improvement (IHI) Breakthrough Series Model and consequently regular networking events will be held throughout the duration of the project to develop communities of expertise.

- **Media and social media** – the project team are currently reviewing social media options to enhance communications. This includes Facebook and Twitter as potential vehicles to spread key messages. Where possible, local press will be encouraged to attend events and receive information in order to raise awareness within the general population.

- **Individuals and teams** – key individual/team stakeholders who play a vital role in supporting the project will be communicated with directly, either through the existing governance structure or through direct communication to ensure they remain up to date with progress and are able to contribute effectively.